Payment Agreement

THIS AGREEMENT made this _____, by and between _____
(Date) (Name)
and Dr. Mimi with Dr. Mimi's Audiology Clinic (Second Party).

TERMS OF AGREEMENT: Both parties agree with the payment agreement terms listed below:

Patients are responsible for the cost of all non-covered services by their insurance. For example, but not limited to, hearing evaluations, hearing aid evaluations, tinnitus evaluations, etc. This includes deductibles, co-insurance, contract exclusions, non-authorized services deemed by their insurance provider to be non-covered expenses and any remaining balances after insurance provider payment.

Patients are responsible for the total cost of the hearing aids and hearing aid accessories quoted by Dr. Mimi during the appointment. (Including those aids and services quoted as a bundled price.)

In the event partial payment or no payment is received from your insurance provider, for your hearing aids and / or hearing aid accessories from your insurance carrier the full balance is due and payable by you, to Dr. Mimi's Audiology Clinic, within 90 days of your initial appointment. We will provide you with an invoice and you may pursue reimbursement directly with your insurance carrier. Any past due balance exceeding the 90-day period as stipulated above will incur a 7% interest charge on the balance.

This agreement shall be binding upon the parties, their successors, assigns and personal representatives. Time is of the essence on all undertakings. This agreement shall be enforced under the laws of the State of California.

This is the entire agreement.

Name:

First Party 1: _____ Signature: _____

Second Party: Dr. Mimi's Audiology Clinic Signature: _____